Washington State Department of Health

Office of Community Health Systems
Volunteer Retired Providers Program
P.O. Box 47853
Olympia, WA 98504-7853
Fax: 360-236-2830

Volunteer and Retired Provider Program
Claims-Made Professional Liability Application

Insurance coverage is provided by Physicians Insurance A Mutual Company.
Please answer **all** questions, and sign and return it to the address listed above.
Contact the VRP Program at (360) 236-2812 or by email at VRPProgram@doh.wa.gov with questions.

Applicant Demographics

Applicant Name	☐ Male ☐ Female
Professional Designation	
Date of Birth	Social Security Number
Physical Address	
City / State / Zip Code	
Email / Phone	

Practice and Rating Information

Date volunteer service begins (mm/dd/yyyy)
Name of clinic that you will be volunteering **(must be a VRP approved clinic site)**
Speciality that you will practice

History

Washington State Medical License Number	
Board Certification Specialty	Month and year issued

1. Will you receive any compensation for your volunteer services? ☐ Yes ☐ No
2. Are you a student? ☐ Yes ☐ No
3. Is your volunteer service in Washington state at a VRP approved site? ☐ Yes ☐ No
4. I understand that I will only perform non-invasive care a defined by:
   Non-invasive care includes the administration of injections, suturing of minor lacerations, and the incision of boils and superficial abscesses. Obstetric care and procedures coded as surgery are not covered under non-invasive medical care. Non-invasive dental care includes diagnosis, oral hygiene, restoration and extraction. Orthodontia, and surgical treatments are not covered by our malpractice VRP malpractice insurance.

Please Initial _____

Professional Profile Questions

1. Have any complaints ever been filed against you with a governmental agency, medical or professional society, or other medical entity? ☐ Yes ☐ No
2. Have you ever been subject to a governmental agency, medical or professional society, or other medical entity's disciplinary proceedings or reviews, or have you ever been notified of intent to pursue such action? ☐ Yes ☐ No
3. If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification or your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by such agency or society? ☐ Yes ☐ No
4. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
5. Has any professional liability insurance carrier ever declined, cancelled, refused renewal, or issued coverage on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature? ☐ Yes ☐ No
6. Have you ever been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency? ☐ Yes ☐ No
7. Has any claim or suit for alleged malpractice ever been brought against you or your professional corporation? ☐ Yes ☐ No

If you answer 'yes' to any questions above, please provide full details for **all** claims even if they have been closed for no payment. Attach a separate sheet if necessary.

Date of Incident	Patient Name
Amount Paid	
Allegations	
For any negative responses, please explain	

Authorization and Release (please read carefully)

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any of my attending or treating physicians, the Washington Physicians Health Program, any prior insurance carriers, prior employers or professional associates and Physicians Insurance or its duly authorized representatives. I hereby release and discharge the providers of information, Physicians Insurance, its duly authorized representatives and the members or consultants of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives. I agree to notify Physicians Insurance immediately, in writing, if there are any changes from which I have described in this application, including changes in my practice, in my partners or associates, medical license, professional office premises, practice locations, medical procedures or administrative responsibilities and hospital privileges. I understand that Physicians Insurance does not cover any liability of another person or organization with whom I assume an oral or written contract or agreement.

Authorized Signature - Required

Date

A photocopy of this Authorization shall be considered as effective and valid as the original.

For Washington, state law requires us to inform you of the following:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please return this form to the address list on page one.